

REC'D SEP 14 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

29510

Do not use this space.

1. PLACE OF DEATH *Laclede, Boone Co*

(a) County ..... Registration District No. *448 316*

(b) Township ..... Primary Registration District No. *5608*

(c) City *Conway* (d) Street No. .... St. ....

(e) Length of residence in city or town where death occurred  
yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT-FULL NAME *James Thomas Eddings*

(a) Residence, No. *354 Conway Mo* St.  (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widowed*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Maggie*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Oct 3 - 1868*

7. AGE YEARS *69* MONTHS ..... DAYS *5* IF LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. .... 9. Industry or business in which work was done, as saw mill, bank, etc. *Farmer.* 10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Christian Mo*

FATHER 13. NAME *James M Eddings* 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Peoria Ill*

MOTHER 15. MAIDEN NAME *Anna Taylor* 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Georgia*

17. INFORMANT *Mrs Esther Bil Conway Mo* (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE *Mt Peah. DATE Aug 30 1939*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Alisa Schmeyer Springfield Mo*

20. FILED *9-11-39* *Gra Montgomery* Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Aug 8 - 1939*

22. I HEREBY CERTIFY, That I attended deceased from *May 2, 1939*, to *June 29, 1939*

I last saw him alive on *June 29, 1939*. Death is said to have occurred on the date stated above, at *2 p. m.*

The principal cause of death and related causes of importance were as follows:

*Chronic Nephritis*  
*Asternal Sclerosis*

Date of onset

Other contributory causes of importance: *131*

Name of operation ..... Date of .....  
What test confirmed diagnosis? ..... Was there an autopsy? *No*

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? ..... Date of injury ..... 19.....  
Where did injury occur? ..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. ....

Manner of injury .....  
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? *No*  
If so, specify .....  
(Signed) *R. H. Froeh* M. D.  
*S. Strappard Mo* (Address)

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer, No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**